STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. BUILDING _____ B. WING _____	03/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN46767

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F0000	This visit was for the investigation of Complaint IN00086742 Complaint IN00086742-Substantiated, Federal/State deficiencies related to the allegations are cited at F223, F225 and F226 Survey dates: 3/20-21/11 Facility number: 000184 Provider number: 155286 AIM number: 100267210 Survey team: Ellen Ruppel, RN Census bed type: SNF/NF: 46 Total: 46 Census payor type: Medicare: 5 Medicaid: 33 Other: 8 Total: 46 Sample: 6 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 3-23-11 Cathy Emswiller RN	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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F0223 SS=D	Based on observation, interviews and record review, the facility failed to prevent verbal abuse by the transport driver to 1 of 6 residents whose records were reviewed for abuse in a sample of 6. Residents C. Findings include: During the orientation tour, on 3/20/11 at 2:15 p.m., the nurse on duty (LPN # 4) indicated Resident C was alert, oriented and interviewable. The resident was observed propelling her wheel chair throughout the facility. The clinical record of Resident C was reviewed, on 3/20/11 at 2:30 p.m., and indicated the resident had been sent to the local psychiatric hospital, on 3/9/11, due to agitation and anger. She had returned on 3/15/11. The resident's diagnoses included, but were not limited to: anxiety, multiple sclerosis and explosive disorder. The most	F0223	Submission of this Plan of Correction does not constitute and admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.The Plan of Correction is prepared and submitted because of requirements under State and Federal law.Please accept this Plan of Correction as our credible allegation of compliance.F223 ABUSE PREVENTIONThe facility will ensure this requirement is met through the following corrective measures:1. Resident #C was not harmed.2. All residents have the potential to be affected. Resident interviews were conducted as part of the facility's investigation and no concerns were noted at this time.3. The Policy and Procedure for Resident Abuse and for Reporting Unusual Occurrences was reviewed and no changes are indicated. The staff have been re-educated on the policies and procedures for reporting abuse (See Attachment A). All allegations of abuse will be reported immediately by staff to the Administrator. One staff member will be questioned by the Administrator or designee daily on scheduled work days x4 weeks, then two times weekly x 4 weeks, and then twice monthly thereafter to ensure continued compliance (See Attachment	04/05/2011

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	recent Minimum Data Set (MDS) assessment, of 3/9/11, indicated she had no problems with long or short term memory and was capable of decision making. Social service notes, dated 2/22/11 at 8:35 a.m., indicated the resident had told the social worker that she had "problems (with) that girl that takes people out places & (and) to appointments." The entry indicated the driver had "crabbed about everything I bought, she said I shouldn't or couldn't buy the things I wanted to buy." The entry indicated the resident was using an electric cart in the store and the driver had told her not to go down a particular aisle, but she did and knocked things down and off the shelves. The social service note indicated the driver had "yelled" at the resident and told her she would never take her anywhere again. During an interview with LPN# 7, on 3/21/11 at 9:40 a.m., she		B).4. The findings of these interviews will be reviewed during the facility's quarterly Quality Assurance Meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before 4/05/11.	

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	indicated she had spoken to Resident C, on Sunday 2/20/11 and was told by the resident the transport driver had yelled at her and told her she would never take her to (name of department store) again. LPN# 7 indicated she had reported the incident to the weekend supervisor (LPN# 10), as the facility policy indicated. She indicated she knew the weekend supervisor was to call the Administrator when an allegation of abuse occurred. She also indicated she was unsure if the weekend supervisor had notified the Administrator, so she had notified the Administrator of the incident. The investigation of the incident was reviewed, on 3/21/11 at 10:00 a.m., and it indicated the transport driver who had been involved and the weekend supervisor who had failed to report the incident immediately to the Administrator had been suspended and			

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	subsequently terminated on 2/22/11. Review of the 1/2006 facility abuse prevention policy provided by the DoN, on 3/20/11 at 2:30 p.m., indicated the Administrator would be immediately notified of suspected abuse. An interview Resident C, on 3/21/11 at 10:30 a.m., indicated she no concerns of anyone being rude or abusive with her. She indicated she would tell the nurse if she had any problems with any staff member or other resident. This federal tag relates to complaint IN00086742. 3.1-27(b)			

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F0225 SS=D	Based on observation, interviews and record review, the facility failed to implement the policy of reporting immediately to the Administrator the allegation of verbal abuse by the facility transport driver to 1 of 6 residents whose records were reviewed for abuse in a sample of 6. Residents C. Findings include: During the orientation tour, on 3/20/11 at 2:15 p.m., the nurse on duty (LPN # 4) indicated Resident C was alert, oriented and interviewable. The resident was observed propelling her wheel chair throughout the facility. The clinical record of Resident C was reviewed, on 3/20/11 at 2:30 p.m., and indicated the resident had been sent to the local psychiatric hospital, on 3/9/11, due to agitation and anger. She had returned on 3/15/11. The resident's diagnoses	F0225	F225 ABUSE/NEGLECT REPORTED TO ADMINISTRATIONThe facility will ensure this requirement is met through the following corrective measures:1. Resident #C was not harmed.2. All residents have the potential to be affected. Residents were interviewed as part of the facility's investigation and no concerns were noted at this time. 3. The Policy and Procedure for Resident Abuse and for Reporting Unusual Occurrences was reviewed and no changes are indicated. The staff have been re-educated on the policies and procedures for reporting abuse (See Attachment A). All allegations of abuse will be reported immediately by staff to the Administrator. One staff member will be questioned by the Administrator or designee daily on scheduled work days x4 weeks, then two times weekly x 4 weeks, and then twice monthly thereafter to ensure continued compliance (See Attachment B).4. The findings of these interviews will be reviewed during the facility's quarterly Quality Assurance Meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before 4/05/11.	04/05/2011

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	included, but were not limited to: anxiety, multiple sclerosis and explosive disorder. The most recent Minimum Data Set (MDS) assessment, of 3/9/11, indicated she had no problems with long or short term memory and was capable of decision making. Social service notes, dated 2/22/11 at 8:35 a.m., indicated the resident had told the social worker that she had "problems (with) that girl that takes people out places & (and) to appointments." The entry indicated the driver had "crabbed about everything I bought, she said I shouldn't or couldn't buy the things I wanted to buy." The entry indicated the resident was using an electric cart in the store and the driver had told her not to go down a particular aisle, but she did and knocked things down and off the shelves. The social service note indicated the driver had "yelled" at the resident and told her she would never take her anywhere again.			

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	During an interview with LPN# 7, on 3/21/11 at 9:40 a.m., she indicated she had spoken to Resident C, on Sunday 2/20/11 and was told by the resident the transport driver had yelled at her and told her she would never take her to (name of department store) again. LPN# 7 indicated she had reported the incident to the weekend supervisor (LPN# 10), as the facility policy indicated. She indicated she knew the weekend supervisor was to call the Administrator when an allegation of abuse occurred. She also indicated she was unsure if the weekend supervisor had notified the Administrator, so she had notified the Administrator of the incident. The investigation of the incident was reviewed, on 3/21/11 at 10:00 a.m., and it indicated the transport driver who had been involved and the weekend supervisor who had			

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	failed to report the incident immediately to the Administrator had been suspended and subsequently terminated on 2/22/11. Review of the 1/2006 facility abuse prevention policy provided by the DoN, on 3/20/11 at 2:30 p.m., indicated the Administrator would be immediately notified of suspected abuse. An interview Resident C, on 3/21/11 at 10:30 a.m., indicated she no concerns of anyone being rude or abusive with her. She indicated she would tell the nurse if she had any problems with any staff member or other resident. This federal tag relates to complaint IN00086742. 3.1-28(c)			

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F0226 SS=D	Based on observation, interviews and record review, the facility failed to implement the policy of reporting immediately to the Administrator the allegation of verbal abuse by the transport driver to 1 of 6 residents whose records were reviewed for abuse in a sample of 6. Residents C. Findings include: During the orientation tour, on 3/20/11 at 2:15 p.m., the nurse on duty (LPN # 4) indicated Resident C was alert, oriented and interviewable. The resident was observed propelling her wheel chair throughout the facility. The clinical record of Resident C was reviewed, on 3/20/11 at 2:30 p.m., and indicated the resident had been sent to the local psychiatric hospital, on 3/9/11, due to agitation and anger. She had returned on 3/15/11. The resident's diagnoses included, but were not limited to:	F0226	F226 DEVELOP/IMPLEMENT POLICIES/PROCEDURES PREVENT MISTREATMENT/NEGLECT/ABUSEThe facility will ensure this requirement is met through the following corrective measures:1. Resident #C was not harmed.2. All residents have the potential to be affected. Residents were interviewed as part of the facility's investigation and no concerns were noted at this time. 3. The Policy and Procedure for Resident Abuse and for Reporting Unusual Occurrences was reviewed and no changes are indicated. The staff have been re-educated on the policies and procedures for reporting abuse (See Attachment A). All allegations of abuse will be reported immediately by staff to the Administrator. One staff member will be questioned by the Administrator or his designee daily on scheduled work days x4 weeks, then two times weekly x 4 weeks, and then twice monthly thereafter to ensure continued compliance (See Attachment B).4. The findings of these interviews will be reviewed during the facility's quarterly Quality Assurance Meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before 4/05/11.	04/05/2011

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	anxiety, multiple sclerosis and explosive disorder. The most recent Minimum Data Set (MDS) assessment, of 3/9/11, indicated she had no problems with long or short term memory and was capable of decision making. Social service notes, dated 2/22/11 at 8:35 a.m., indicated the resident had told the social worker that she had "problems (with) that girl that takes people out places & (and) to appointments." The entry indicated the driver had "crabbed about everything I bought, she said I shouldn't or couldn't buy the things I wanted to buy." The entry indicated the resident was using an electric cart in the store and the driver had told her not to go down a particular aisle, but she did and knocked things down and off the shelves. The social service note indicated the driver had "yelled" at the resident and told her she would never take her anywhere again.			

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	During an interview with LPN# 7, on 3/21/11 at 9:40 a.m., she indicated she had spoken to Resident C, on Sunday 2/20/11 and was told by the resident the transport driver had yelled at her and told her she would never take her to (name of department store) again. LPN# 7 indicated she had reported the incident to the weekend supervisor (LPN# 10), as the facility policy indicated. She indicated she knew the weekend supervisor was to call the Administrator when an allegation of abuse occurred. She also indicated she was unsure if the weekend supervisor had notified the Administrator, so she had notified the Administrator of the incident. The investigation of the incident was reviewed, on 3/21/11 at 10:00 a.m., and it indicated the transport driver who had been involved and the weekend supervisor who had failed to report the incident			

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	immediately to the Administrator had been suspended and subsequently terminated on 2/22/11. Review of the 1/2006 facility abuse prevention policy provided by the DoN, on 3/20/11 at 2:30 p.m., indicated the Administrator would be immediately notified of suspected abuse. An interview Resident C, on 3/21/11 at 10:30 a.m., indicated she no concerns of anyone being rude or abusive with her. She indicated she would tell the nurse if she had any problems with any staff member or other resident. This federal tag relates to complaint IN00086742. 3.1-28(a)			

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